

Positive Community Care Limited

Hawthorn Farm

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection took place on 26 and 27 October 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day.

The last inspection visit took place on 29 April 2015 and the service was rated Good.

Hawthorn Farm is part of Positive Care, a family run business which provides support to people with mental health needs and has one other location. Hawthorn Farm is registered to provide accommodation and personal care for up to 11 people who have mental health needs. At the time of our inspection there were 11 people living at the service.

The day to day running of the home was undertaken by the unit manager who the registered manager worked closely with to ensure the service was run effectively. The registered manager was the registered manager for both of Positive Care's locations and a director with Positive Care. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection, we saw medicines were not always managed safely.

Staff appraisals were not all up to date. We recommended that staff receive support through appropriate professional development to enable them to carry out their duties.

The service had a safeguarding policy. Staff had attended safeguarding training and knew how to report safeguarding concerns. Risks assessments were in place to minimise the risk to people using the service and staff knew how to record incidents and accidents. The provider followed safe recruitment procedures.

There were service checks carried out to ensure the environment was safe.

Staff had the relevant skills to care for people using the service and were supported through supervision and training. There were enough staff to meet people's needs.

Mental Capacity Act 2005 guidance was being followed and people had choices.

People were supported to have enough to eat and drink and were able to have food and drinks when they wanted to.

People had access health care services and the service worked with other community based agencies such as the community mental health team.

People who used the service told us staff were kind and their dignity and privacy was respected.

Care plans were person centred and up to date. We saw people were involved in contributing to their reviews.

An appropriate complaints procedure was available.

The service had systems to monitor the quality of service delivered and to ensure the needs of the people who used the service were being met.

The unit manager and registered manager were approachable. Staff and people using the service said the managers listened to what they had to say.

Renovation works for the home were being planned for the end of 2016.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe because medicine stock balances and recording were not always being safely managed.

There were procedures in place to safeguard people from the risk of abuse and staff knew how to respond if they suspected abuse.

Risk assessments minimised harm to people using the service.

There were a sufficient number of staff.

Requires Improvement ●

Is the service effective?

The service was effective.

However, not all staff appraisals were up to date and we recommended that staff receive support through appropriate professional development to enable them to carry out their duties.

Staff received training and supervision to have the skills to care for people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS were in place where required and staff understood people's right to choose.

People were supported with food and drink to meet their individual needs.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals.

Good ●

Is the service caring?

The service was caring.

Staff recognised people's choices.

People's privacy and dignity were respected.

Good ●

People were supported to maintain relationships with family and friends.

Is the service responsive?

The service was responsive.

Staff were aware of people's individual needs and care plans. People contributed to their care plans and reviews.

There was a complaints procedure. People and their relatives said they would speak with the unit manager or registered manager about concerns they had.

Good ●

Is the service well-led?

The service was well led.

The unit manager had recently been appointed and had the skills and knowledge to manage the service. People who used the service, relatives and staff said the registered manager and the unit manager were approachable.

The service had systems to monitor the quality of the service delivered to ensure the needs of the people who used the service were being met.

Renovation works for the home were being planned for the end of 2016.

Good ●

Hawthorn Farm

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 26 and 27 October 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day.

The inspection was conducted by a single inspector.

Prior to the inspection, we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team and Safeguarding Team for feedback of their knowledge of the service.

During the inspection, we spoke with five people who used the service and interviewed five staff members including the registered manager and the unit manager. We looked at the care plans for four people who used the service. We also saw files for six staff which included recruitment records, supervision and appraisals and we looked at training records. After the inspection we spoke with six relatives, one health care professional and two social care professionals.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

Is the service safe?

Our findings

The service did not always manage medicines safely. In August 2016, a whistle blower raised concerns around medicines management at the service and this information was passed on to the local authority. The local authority visited the service on 14 October 2016 and concluded it was not necessary to proceed with a safeguarding investigation. Further concerns around medicines management were raised at the inspection on 28 October 2016 and these were also referred to the local authority.

During the inspection on 28 October 2016 we looked at medicines administration records (MAR) for three people and the controlled drugs administration for one person. MAR charts included people's photos and identified allergies. Medicines were dispensed from blister packs and from individual boxes and bottles. One person's blister pack was out of synchronisation and we were told this was because staff had dispensed the medicine from both an individual box and the blister pack. The recording on the MAR chart for the same person was unclear as to when they had missed taking medicines, if they had taken them later, for example because they had been sleeping, or if they had planned to be out of the home and taken their medicines with them. In addition to the discrepancies in the recording of medicines administered, the samples of stocks we counted could not be reconciled with the MAR charts. We saw a separate book to count stock and this reconciled with the surplus stock but was not cross referenced with the MAR chart so was not effective as the MAR chart indicated discrepancies. Medicine audits, which were being undertaken weekly, had not identified the inconsistencies. Consequently, we could not be sure that medicines were being administered safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a medicines policy and we saw as required (PRN) protocols which noted the required information for PRN medicines. Controlled drugs were stored safely and we saw two signatures when these drugs were administered. All staff who administered medicines had completed training in the last year.

Immediately after the inspection, a meeting was held with staff to address the medicine administration concerns raised during the inspection. Actions taken included identifying two people to do the weekly medicines audit on a new template. This will be supervised by the unit manager and the audit will ensure that all MAR chart recording is correct. MAR sheets will be checked by two staff members when medicines are being administered and the service will use newly created medicines order forms. All staff administering medicines will complete refresher training and have their medicines competency assessed by the unit manager.

People using the service, their families and professionals told us it was safe. Three people we spoke with told us they felt safe in the home, saying "Yeah I feel safe." Other comments included, "They're safe when they're in the building", "(Person) is safe there", "I do think (person) is safe" and "Once (person) is in the home, I feel they are safe, but they are at liberty to come and go as they please."

The service followed safe recruitment procedures. We viewed the files of six staff and saw application forms, two references, Disclosure and Barring Service (DBS) checks, proof of identity and where required proof of permission to work. This meant the provider had taken measures to ensure staff were suitable to work with people using the service.

Support workers we spoke with had attended safeguarding training, were able to identify types of abuse and said, "I would report it straight away to my manager" and "If I had any concerns I would speak to the manager and if not, the social worker or community psychiatric nurse."

Risk plans for people using the service were clear with the stated risk, how to minimise it and guidelines for how staff should respond. Staff also told us they knew how to support people who expressed their feelings in particular ways, and if there was an incident, staff had a debriefing session to reassure the staff involved and to help the team build on their skills.

The service had a contingency plan but it did not include what the alternative arrangements would be if the service could not use the building. The deputy manager agreed to update this. We saw up to date safety checks for fire equipment and weekly fire alarm tests. A fire risk assessment for the service had been completed on 20 April 2016. The fire and emergency evacuation procedures provided information on what to do in the event of a fire and fire drills were every three to six months. People had personal emergency evacuation plans (PEEPs). Fire drills recorded people's reactions, evacuation times and conclusions. The fire alarm system was last serviced on 03 January 2016 and fire extinguishers were serviced by an external agency on 09 December 2015. The service completed portable appliance (PAT) testing, legionella testing and had an up to date gas safety certificate. There was also a monthly control of substances hazardous to health (COSHH) audit.

The service had procedures for whistle blowing, accidents and incidents, lone working, control of substances hazardous to health (COSHH) and a smoking policy and procedure. There was no smoking in the home, except in the designated smoking room and this was stated in the house rules which people had copies of. The unit manager had recently sent out letters reminding people smoking was not allowed in bedrooms. The service had a fully enclosed but separate smoking room attached to the side of the building, which was only accessible from outside.

The service had a number of allegations of criminal behaviour and of missing persons which we saw were appropriately raised as notifications to the Care Quality Commission (CQC). There were no safeguarding incidents in the last year and there was one whistleblowing report to CQC. Staff knew how to record incidents and accidents and to inform the manager. The incident reports we saw were clear in detailing what happened, what the responses were, who had been notified and were signed by the staff member recording it and the unit manager. Each person had an incident tracker, which was a chronology with a brief description of the incidents, triggers and actions. It was reviewed and updated monthly by the deputy manager. The unit manager told us they were currently developing action plans for reoccurring incidents to provide staff with more information on how to employ strategies. Additionally they had created a positive behaviour plan to support staff to use effective strategies as a response to issues identified and to support people's wellbeing and safety.

Relatives told us there was a high staff turnover and this had affected the quality of their communication with the service. A professional told us, "Understandably, through the time, there has been high turnover of staff members which may have direct impacts and influences on the level of care delivered. Service users have their own expectations and due to these changes, they feel the continuity of care gets disrupted. Also, service users have preferences, likes, dislikes and find it hard to build a therapeutic rapport when they see

different faces." The registered manager confirmed that staff had left in the last year but the service had recruited more staff, including a unit manager who had been employed a month before our inspection.

The service employed ten members of staff and during our inspection we observed there were enough staff to meet people's needs. The registered manager told us staffing was based on the needs of the service and people using it and most people went out independently. If the needs of a person changed, the registered manager said the staffing could increase. In addition, when a new person moved in, staffing could temporarily increase. We were told it was very rare for the service to use agency staff.

The service supported ten out of eleven people using the service to manage their money. Each person had an individual ledger recording in and out transactions which were checked by staff daily at each handover and audited weekly by the manager to ensure the ledgers balanced and people's money was being managed appropriately.

Is the service effective?

Our findings

We saw evidence that support workers were supported to have the skills and knowledge they required to carry out their role through inductions, training and supervisions. Staff we spoke with told us they had an induction and shadowed more experienced staff for several days. We saw induction books in staff files and the unit manager said new staff had a six month probation period. A professional told us staff supported people using the service who had, "needs which are very complex and difficult to be managed in the community. However, they have been sustained in the community due to the robust package of care in place. I have no major area of concern nor any safeguarding issue with effect to standard of care delivered to the mutual service users."

Training was recorded electronically and reviewed manually but an electronic system was being implemented that will alert managers when staff are due training. Training the provider considered mandatory included, medicines, health and safety, fire awareness, deprivation of liberty safeguards (DoLS), Mental Capacity Act, data protection and yearly adult safeguarding training. As part of their on line training, staff had to complete quizzes to demonstrate their understanding of the course material. Good practice was discussed during team meetings and handovers. The unit manager worked alongside staff two days per week, which gave them the opportunity to observe staff practice and they told us if they noticed any poor practice, they addressed it immediately. Key areas of concern were identified through supervisions. Staff had on line training and liaised with the supplying pharmacist for medicines training.

Supervisions were every four to six weeks and appraisals were yearly. A support worker told us during supervision, "We ask questions, what (the supervisor) is not happy with. (The supervisor) tells me what I've improved and if they have any concerns." Not all the files we viewed contained up to date appraisals. This meant staff did not have the opportunity to reflect on their strengths, areas for improvement or to set goals for the following year.

We recommend that staff receive support through appropriate professional development to enable them to carry out their duties.

Most relatives said staff kept them informed. However, one family were not happy with the level of communication between themselves and the service. They thought a high staff turnover contributed to this and meant they had to explain situations again from the beginning. They said they had met with the management but remained unhappy about the situation and did not feel they were kept updated. Another relative told us staff changed "frequently" which meant relatives had to continually explain "to get staff up to speed" with their relative's needs and care plan. Other comments included, "I have been contacted by email whenever we need to discuss my (relative's) care. Communication is very good", "(Staff) let me know about most things" and "They are good and do inform me of things that are going on."

Support workers said there was good communication in the service. There was a handover book for the morning, afternoon and waking night staff to record people's medicines administration, emotional and social wellbeing and if they went out. A professional said, "I receive regular feedback through emails about

any incidents, accidents, concerns and other relevant information." They considered the service demonstrated best practice through, "Maintaining regular contacts with stakeholders, providing feedback about progress and also having service users' interests at heart. (They) attempt to focus on recovery care pathways."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA and had appropriately applied for DoLS. One person had their DoLS authorised and a second person's application was pending.

Comments from people using the service included, "Of course I can go out when I want to" and "Can go out but have to be back by 10pm. Saturday and Sunday (I) can go home." A social care professional told us, "(Person) is free to come and go from the home and when they go missing (staff) call the police." Staff said, "We have two people here with DoLS. They can't make decisions by themselves and they have advocates" and "Everyone has a choice – can be a good choice or a bad choice. Even though they are ill, it doesn't mean they don't have a choice. Even people on DoLS can make choices. Everyone has a right to make choices."

People we spoke with said they were satisfied with the food. They told us they could make decisions about the menu and "(I) can say no I want something else", "Staff cook food and I like eating it" and "The food is good." Staff prepared meals and some people using the service liked to help with cooking or setting the table or tidying up afterwards. Staff knew about individual dietary needs through the nutrition section of people's care plans. The only specific dietary need some people in the service had was that they ate halal food. This was catered for and there was a variety of cultural dishes served through the week that everyone ate. We saw people could help themselves or get support in the kitchen. Three people in particular liked to cook with staff and during the inspection we saw them cooking a curry with staff support. People had a choice of menus and we saw weekly records of people's individual choices.

People who used the service were supported to maintain good health. A healthcare professional said an example of good practice was staff "Observing and looking out for patients with complex and chronic mental and physical health problems... We receive prompt contact from Hawthorn Farm if there is any deterioration in (person's) condition, which allows us to assess them early before any worsening of their condition, preventing possible hospital admission. Whenever I have visited Hawthorn Farm to see my patients, I observe my patients are always treated with respect and dignity by the care staff. (Deputy) care manager is particularly helpful and caring with the residents. Even when a difficult situation arises they acted professionally to contain the situation and sought urgent assistance." Another professional said, "Generally, any change of treatment regime are implemented straight away. A letter is sent to the general practitioner who would then prescribe regarding any change of medication. When (people) need mental health support, (staff) seek it" and a relative told us, "(Person) has been seriously unwell and they acted quickly to get (person) the care they needed." People's files had evidence of professional involvement including care co-ordinators, community psychiatric nurses, GP, mental health nurses and the drug and alcohol team. If someone attended an appointment with a GP, this was recorded in his or her medical

folder.

Is the service caring?

Our findings

When we asked people if staff were caring toward them, they said, "I don't mind living here. Staff are not too bad", "It's alright here", "I can talk to staff", "Staff know what to do with medication and things like that" and "They help me out with letters, appointments and medication. They give us money. They're alright."

The managers told us where people have relationships with family and friends the staff encourage people to maintain these and the service has an open door policy. Families also come to the home for open events. Relatives told us, "They do a great job, my (relative) is cared for by staff who are professional, and caring", "They (staff) are taking care of (person). (Staff) ring to remind (person) to come back for their injection", "Hawthorn has been the most stable place for (person). (The deputy manager) is absolutely wonderful. (Person) is very fond of them", "They look after (person) very well. I'm very pleased with where they are. (Person) can be quite demanding and insist upon your attention and the care home deal with it very well", "Staff are kind and caring. From what I've seen, they are very respectful and caring", "(The deputy manager) is very interactive with the residents. They do a very good job" and "We had looked at 20 care homes and Hawthorn was the best by far. From the moment we went through the doors, we were made very welcome." A professional said, "When I get there, residents seem relaxed. It's a homely atmosphere."

Staff told us independence was promoted through giving people choices, for example, taking money to do their own shopping, going to visit their family by bus, cleaning their bedrooms with supervision and being supported with budgeting skills when they are out shopping. Another support worker said, "We give them choice. When we are doing something we ask what they want." If a person came in to the kitchen for drinks or a snack, rather than make it for the person, staff would supervise them to do it themselves.

People's privacy and dignity was respected. Staff knocked on doors before entering people's rooms. When we asked support workers how they supported people with personal care, they told us they "prompted and guided" people with personal care as "no one here needs hands on personal care." Other comments included, "First and foremost is their dignity. Make sure doors are closed. Ask them – especially for males - because they may not want me (female) to support. It all comes down to dignity", "I always knock before I enter. I always ask if they want their privacy when having a shower" and "You have to give people their privacy. Some people here choose who they like to support them with personal care. We respect their dignity and choices. We communicate with them and tell them what the benefits are if they refuse and we approach them in the right manner."

The service user guide had pictures to make it more user friendly. It included information about key working, staff responsibilities, residents' meetings, the accident procedure, fire procedure and the complaints procedure, which was signed by people using the service, and it provided various contact numbers. Each person using the service had an allocated keyworker to talk about their care plan with and had wellness recovery action plan booklets, which recorded how they wanted staff to support them.

Is the service responsive?

Our findings

We reviewed people's files to see if individual needs and preferences were met. Prior to people moving into the home, we saw their social worker sent through an assessment and then the service completed their own. People's initial assessment forms included information about their individual background, mental health needs, physical health and social information. Files included information regarding people's primary diagnosis, a one page profile that recorded what was important to people and how best to support them, contracts of care signed and dated by people using the service and the house rules. There was a smoking agreement to smoke in designated areas only and the smoking policy was attached. Agreements were signed and dated by people using the service.

People using the service were aware they had care plans. One person confirmed that they had a care plan and both their family and care co-ordinator attended reviews. Care plans included information regarding personal information, preferred name, likes and dislikes, medical needs, dietary requirements and cultural needs. They recorded activities, daily living skills, financial support, medical needs, nutrition, personal care self-neglect, social life and weight management. Each file had a summary of needs and used the same headings to provide more detail noting the current situation, expected outcome, actions and a daily record which were all dated within the last year. For example under one person's daily living skills there was information on when the person required prompting and when they required supervision. It noted they preferred their own space and quoted the person saying they did not like to use soap. There was space at the back of the care plan for people to write objections and comments. The care plan was signed and dated by the person using the service and the unit manager. Staff then also signed and dated the care plan to confirm they had read it.

People had reviews every six months but files were updated accordingly in between reviews and were considered live person centred documents. For people who could not read, staff told us they read the care plans to people who then signed them. The service sought input from the family and the care co-ordinator. The service also wrote up minutes from psychiatric reviews held in the home. A professional said, "We have regular psychiatric reviews and it provides a platform to share information. As well, there are regular placement reviews as (local authority) is the funding authority and this is to ensure all agreed outcomes are achieved."

Where required, the service kept charts such as people's weight. We saw a personal care chart that recorded if the person had taken a bath or shower, the level of support they needed and comments. The comments indicated the person often refused but staff would try to persuade them to shower and were often successful. Additionally we saw a comprehensive daily chronology completed after each shift that recorded people's appointments and what they did during the day.

People's files included a record of multi professional meetings, notes from other professionals such as the community psychiatric nurse and records of medical and mental health appointments attended. In some peoples' files we saw wellness recovery action plans (WRAP) in easy read format that recorded things that helped people to stay well and how to reduce unpleasant experiences.

Staff told us, "We have care plans and we have key working sessions. We have them once a month and record them. Then we do key working progress reports every quarter. Sit down and have a chat with them and you find things out." Key working sessions were recorded monthly with an agenda for guidance and then summarised into a quarterly progress report. However, key working sessions were not always written down. The deputy manager was addressing this by scheduling it on the rota during staff administration time. People using the service said, "Get one to one sessions with staff. Talk about the usual – happiness", "I have a key working meeting for one to ones" and "I do try to do my best. Staff help me."

When asked what kinds of activities they did, people told us, "I read, listen to music and go to the library", "We do exercises in the morning here", "They book trips for us now and again" and "I stick to my activities. I do arts and crafts. I work in (area) in a shop called (X). I wash the dishes and floor." The service had an activity folder with a weekly planner for each person and an activity card that recorded what people did each day. Activities included life skill activities, community activities with the provider's other location, budgeting skills, one person was studying French and local walks. Most people could access the community independently and when they returned to the home, staff said they asked where people had visited and recorded it in their file. The file also included numerous photographs of people doing various activities.

In 2015, five people went to Paris and other people went to a British holiday camp both in 2015 and 2016. One person said about going to Paris, they "Could chill out and we had a laugh." Another person showed us their memory book. It had photos of both people and places past and present. Some photos indicated the person's past occupation and other specific interests and there was present day photos of recent activities. They were able to comment on the photos and appeared satisfied with their book. Relatives comments about activities included, "(Staff) do try to encourage (person) to interact" and "They could do with more staff to meet the patient's needs and a mini bus but I know they do take them out in cars."

The service had a complaint procedure but had not received any complaints in the past year. People told us they would tell a member of staff if they had a complaint. One person said, "Say you want to make a complaint and tell staff. I made a complaint once and they talked to me and the other person." Relatives told us they had the management's contact details if they had a concern or wanted to complain. Comments included, "When (person) has come home, they've not had any complaints" and "If I had a complaint, I would speak to the manager. I have in the past (and the issue was resolved)."

The communal hall had information and contact details for a number of different agencies including advocacy services and the Care Quality Commission. There was also a complaints form, newsletter and information about activities.

Is the service well-led?

Our findings

People using the service, relatives and staff said both the unit manager and registered manager were approachable. The unit manager's interactions with people using the service indicated a good level of knowledge around people's needs. Relatives told us, "Yes, I talk to (the unit manager) and (registered manager) and I've spoken to (the deputy manager) and they're very good." The unit manager said they had good relationships with families. "All the clients here have mental health needs and we try to have a good rapport with everyone who provides support." A professional said, "(The manager) is always happy to meet with me and talk to me" and "The manager follows through." Staff told us they would speak to either the unit manager or the registered manager. "They listen" and "If I had a concern I would speak to (the registered manager). If you are not happy with the rota, she will change it. She listens."

The unit manager said, "We respond to any feedback and I feel we react and put in good practices." They gave an example of one person who was repeatedly smoking in their bedroom. The person said it was because they felt they could not ask staff to continually take them to the smoking area. Staff identified what times of days the person liked to smoke and consequently now offer to take the person to smoke in a designated area so this has limited the person smoking in their bedroom.

During the inspection, we saw people using the service go into the office to speak to the unit manager. The registered manager and unit manager were both present and available to staff. They explained communication was important and we saw a handover folder, communication book and 24 hour on call system to provide support to staff.

Surveys to gather feedback from all stakeholders were completed annually. We saw three care and medical professionals had responded with feedback to the service and it was positive. The last staff survey was in April 2016 and three staff responded with mixed comments. Five relatives returned the visitor/family survey in May 2016 and they all said were satisfied with the service. The residents' survey from August 2016, provided a summary of information, noted things to improve and that it should be discussed at the next residents' meeting. Overall people felt safe and satisfied with the level of care provided.

The service had monthly residents' meetings. The voices of people using the service was evident and minutes were typed up so people who did not attend could see them. One person said of the meetings, "They're useful." We saw in the minutes of 18 September 2016, the most recent survey results, food choices, the right to make choices and the complaints procedure were discussed. We also saw a newsletter which kept people informed of events and activities.

Team meetings were held once a month. Staff told us, "They (management) will bring any concerns or changes. They open the floor for everyone to say." We saw minutes from the last staff meeting held 26 September 2016. Topics included record keeping, key working, accident and incident records, care plans, rotas and menus. Previous meetings were held in May and June 2016.

The service had systems to monitor the quality of the service delivered including an electronic system that

alerted managers to when people's care plans or risk assessments needed to be reviewed. The service employed an external consultancy agency to audit them. The last audit was in August 2016 and the unit manager had developed an action plan to address the issues identified in the audit.

The service kept up to date with current best practice and legislation through professional magazines and they received Care Quality Commission provider updates. Any information they considered significant, was posted on the shared drive so all staff could view it.

One relative said, "Overall we are happy, but improvements regarding the property need to be addressed. We were told work will be done, but nothing has happened yet." The registered manager told us renovations to the building were planned for the end of 2016 but they did not yet have written plans for this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment were provided in a safe way for service users because there was not always proper and safe management of medicines. Regulation 12 (2) (g)